NO. 48394-7

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

SHANTANU NERAVETLA, M.D.,

Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

BRIEF OF RESPONDENT

ROBERT W. FERGUSON
Attorney General

TRACY L. BAHM
WSBA No. 22950
THOMAS F. GRAHAM
WSBA No. 41818
Assistant Attorneys General
1125 Washington Street SE
Olympia, WA 98504-0100
(360) 664-9006

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

Regulations

I. INTRODUCTION

The Medical Quality Assurance Commission (MQAC or Commission) has the authority to determine if a licensed physician is unable to practice with reasonable skill and safety to patients due to a mental condition. Once they determine a physician is unable to practice safely, the Commission can impose sanctions to protect the public.

The Commission determined that Dr. Neravetla suffered from a mental condition known as Disruptive Physician Behavior which impairs his ability to practice medicine with reasonable safety and skill. From the time Dr. Neravetla began his one-year residency at Virginia Mason Medical Center (VMMC), he had problems. He was late to rounds, skipped mandatory lectures, disappeared while on pager duty without explanation, and, most importantly, seemed completely unable to hear or process any feedback that was not positive. The VMMC program managers were concerned that he was not gaining the skills and knowledge he needed to become a well-rounded, properly trained doctor. VMMC counseled Dr. Neravetla, gave him coaching, placed him on probation when his behaviors failed to improve, and finally referred him for a mental health assessment. Ultimately, Dr. Neravetla underwent a three-day, multi-disciplinary comprehensive evaluation that concluded he

has a mental condition/occupational problem of disruptive physician behavior that impairs his ability to practice, and that requires treatment.

The Commission issued a Statement of Charges after Dr. Neravetla refused to follow through with treatment. This was followed by a hearing. The Commission determined that, for purposes of RCW 18.130.170(1), Dr. Neravetla's mental condition was sufficient to impair his ability to practice with reasonable skill and safety. As the sole sanction, the Commission required that if Dr. Neravetla applied for a Washington physician license, he must be re-evaluated and be required to comply with any treatment recommendations made by the new evaluator.

Dr. Neravetla fails to demonstrate an error under the Administrative Procedures Act with regard to interpretation or application of law, RCW 34.05.570(3)(d), constitutional violation, RCW 34.05.570(3)(a), findings of fact, RCW 34.05.570(3)(e), or appearance of fairness, RCW 34.05.570(3)(g). Nor does he demonstrate any arbitrary and capricious actions by the Commission, RCW 34.05.570(3)(i). The Commission's Final Order should be affirmed.[1]

[1] A copy of the Medical Quality Assurance Commission's Findings of Fact, Conclusions of Law and Final Order is included as Attachment A to this brief.

II. COUNTER STATEMENT OF ISSUES

1. Does RCW 18.130.170(1) authorize the Commission to consider more conditions than just objectively diagnosable "mental disorders" to protect public safety?

2. Does RCW 18.130.170(1) have a plain and understandable meaning such that it is not unconstitutionally vague when read with legislative intent and in the context of Commission discipline?

3. Were the Commission's Findings of Fact and Conclusions of Law supported by substantial evidence when viewed in light of the whole record?

4. Is the Commission's Final Order arbitrary and capricious under RCW 34.05.570(3)(i) when the Commission expressly considered both parties' evidence and legal arguments?

5. Does it violate the Administrative Procedures Act Appearance of Fairness doctrine, RCW 34.05.570(3)(g), when a hearing panel member fails to recuse himself after declaring that he can act with neutrality and impartiality despite a minor professional association with one hearing witness?

6. Has Dr. Neravetla prevailed under RCW 34.05.570(3)(d) by showing an abuse of discretion in any administrative evidentiary decision?

7. Is it impossible for Dr. Neravetla to comply with the Final Order when he is currently in compliance with the Order and has failed to offer evidence of undue harm?

III. STATEMENT OF THE CASE

A. Overview Of The Uniform Disciplinary Act

The Medical Quality Assurance Commission is the state agency that regulates the practice of physicians, chapter 18.71 RCW, in Washington. The mandate of the Commission is to protect the public's

health and safety and to promote the welfare of the state by regulating the competency and quality of physicians. RCW 18.71.002, .003. Once licensed to practice in Washington, even on a limited license, the Commission retains jurisdiction and authority under the Uniform Disciplinary Act (UDA), chapter 18.130 RCW, to discipline the licensee for either unprofessional conduct, RCW 18.130.180, or to sanction the licensee who is suffering from "any mental or physical condition" that impairs the capacity of the license holder to practice with reasonable skill and safety, RCW 18.130.170(1). RCW 18.71.002, 18.71.195, 18.71.230.

The UDA sets out the standards of unprofessional conduct and the process for disciplining all health care professions within the state of Washington. RCW 18.130.080 et seq. Pertinent here, upon receipt and investigation of a complaint, the Commission decides whether to charge a licensee with unprofessional conduct, RCW 18.130.090, lack of capacity to practice due to any mental or physical condition, RCW 18.130.170, or to close the case without charging. If the Commission finds, after a hearing, that the licensee is in violation of either the unprofessional conduct or impaired capacity provisions, it must issue sanctions under RCW 18.130.160. Those sanctions are designed to first protect the public health and safety, and then to rehabilitate the licensee if possible.

Specific rules dictate the required content of charging documents under either RCW 18.130.170(1) or 18.130.180, which Dr. Neravetla has not challenged. *E.g.* WAC 246-11-250 (Form and content of initiating documents). The initiating document, a Statement of Charges (SOC), must include the "factual basis for the action or proposed action set forth in the document" and any "statutes and rules alleged to be at issue." In this case, the SOC included the factual allegations against Dr. Neravetla and notice that RCW 18.130.170(1) was at issue.

B. Disruptive Issues At Virginia Mason Medical Center

Dr. Neravetla came to VMMC in June 2011 for a year-long residency program called a "transitional year" residency before he was to enter into a residency in his chosen area of specialty, ophthalmology. AR 1603, 1924. He was granted a limited license to practice as a resident physician and surgeon in Washington State. Final Order 1.1 at AR 1603. In this program, each resident would rotate through a series of medical specialties, staying in each one about a month. Dr. Neravetla's first rotation was in internal medicine. AR 1926. In early July 2011, Dr. Neravetla had his first meeting with Dr. Dipboye, the Program Director for the Transitional Year Residency Program at VMMC. AR 1926. In the initial weeks of the residency year, Dr. Dipboye received negative feedback about Dr. Neravetla's performance during the first rotation and

met with him to address it. AR 1927-1935. Additional problems surfaced after that meeting, and Dr. Neravetla, Dr. Dipboye, and Dr. Owens (Dr. Dipboye's supervisor) met later in July 2011. AR 1939-1947, 1434-35. Problems included timeliness, absenteeism, communication issues with team members, performance as far as patient care, and the inability to locate Dr. Neravetla when he was supposed to be at work. AR 2213, 2215. In August, Dr. Neravetla missed two of four mandatory lectures. AR 1948. Dr. Neravetla was then given a verbal warning by Dr. Dipboye and Gillian Abshire, the manager of Graduate Medical Education at VMMC. AR 1948, AR 1789-90 (Exhibit D-4).

Dr. Neravetla continued to have problems with attendance and attitude, and in November 2011 he was given a written warning and formally placed on probation. AR 1439-40, AR 1791-93 (Ex. D-5). As part of his probation, Dr. Neravetla was required to attend a course as well as coaching sessions with Dan O'Connell, Ph.D, a psychologist hired by VMMC at its own expense to help Dr. Neravetla. AR 1956. Dr. O'Connell reported after spending some time with Dr. Neravetla that he was shocked at his lack of insight, and startled that Dr. Neravetla exhibited no humility or openness to criticism or encouragement of feedback. Final Order 1.2 at AR 1604, AR 2073. His impression was that Dr. Neravetla

clearly did not think he needed coaching and was not receptive to it. AR 2078, 2090-91.

Dr. Neravetla exhibited improvement during his residency only when he began his elective rotation, ophthalmology, the field that he planned to enter. During that rotation Dr. Dipboye observed Dr. Neravetla was at the hospital early. He also received reports from the attending physician on that rotation that things were going fine. AR 1959-60. But during his surgery rotation that followed, the problems returned. AR 1960-63. A social worker filed a Patient Safety Alert[2] (PSA) regarding Dr. Neravetla and his interactions with a nurse. The social worker reported that he had tried to page Dr. Neravetla two days in a row regarding orders on a patient and either did not get a response or did not get one that made sense. The social worker also observed Dr. Neravetla behaving in a belligerent way with a nurse and then stomping off. He reported that in his interactions with Dr. Neravetla he didn't seem to be processing information normally. Dr. Dipboye responded to the PSA by checking with the senior residents who were currently working with Dr. Neravetla and received information that Dr. Neravetla was not capable of

[2] A Patient Safety Alert (PSA) is a system at Virginia Mason that Dr. Dipboye described as being "equivalent to the line that the auto assembly person has to pull at Toyota that stops the entire assembly line if they spot a defect. It could be anything that potentially could impact patient safety... they force executives to pay attention to what's happened and to try to identify process errors, if possible." AR 1960-61.

taking care of patients. AR 1962-63. In February 2012, the Transitional Year Educational Committee met and decided to refer Dr. Neravetla for an evaluation of fitness for duty. AR 1966-70, 1442-44, 1794-97 (Ex. D-6).

C. Disruptive Issues At Washington Physician's Health Program

Dr. Meredith and Mr. Green from Washington Physician's Health Program (WPHP) met with Dr. Neravetla on February 16, 2012 and observed many of the same behaviors that were the basis of his referral to WPHP. Dr. Neravetla was angry, defensive, minimized his role in any of the problems, and blamed others for all of his problems at VMMC. AR 2117, 1604. One professional at WPHP described Dr. Neravetla as having a temper tantrum in WPHP's office. AR 2347. He frightened the receptionist to the point of tears. Final Order 1.4 at AR 1604, 2128. WPHP described that Dr. Neravetla presented as boastful, arrogant, haughty, demanding of special treatment, and petulant when he does not get his way. AR 2262. Dr. Neravetla refused to sign consent forms for WPHP to communicate with VMMC. AR 2348. Based in large part on Dr. Neravetla's behavior during their informal assessment, WPHP referred him to get a comprehensive, multidisciplinary evaluation at his choice of three pre-approved centers. AR 2349. Dr. Neravetla did not indicate that he was going to follow through with the referral. *Id.*

In March 2012, based on the belief that Dr. Neravetla did not intend to follow through with the referral and because of ongoing concerns about his fitness to practice, WPHP notified the Medical Commission that they could not endorse Dr. Neravetla as safe to practice. Final Order 1.8 at AR 1606, 1446, 2130.

D. Pine Grove's Assessment

A couple months later, on May 22, 2012, without informing WPHP, Dr. Neravetla presented himself to Pine Grove Behavioral Health Center (Pine Grove), one of the three centers pre-approved by WPHP. Final Order 1.5 at AR 1605. He was first evaluated by Dr. Ed Anderson, Ph.D., who found Dr. Neravetla to be "quick to respond to any probes of his possible role or responsibility or fault with deflection, denial, minimization, and blame." AR 1452, 2253. Dr. Anderson conducted psychological testing, although he indicated when dealing with disruptive behavior that testing is not that important because disruptive physicians are rarely open reporters of their own behaviors. AR 2257. Therefore, collateral information, such as talking to individuals from the workplace and/or the referring entity, becomes essential to disruptive physician evaluations, along with how the physicians present in person. AR 2258. Pine Grove chose the first two collateral sources to contact (Dr. Dipboye from VMMC and Dr. Meredith from WPHP), and allowed Dr. Neravetla

to choose five collateral sources to be contacted. AR 2260. Dr. Neravetla originally refused to sign a release for any collateral sources to be contacted, but later agreed to let WPHP and VMMC be contacted when advised that the evaluation could not be completed without those contacts. He still refused to sign a release for Pine Grove to talk to Dan O'Connell, Ph.D., the professional who had served as his coach at VMMC. AR 2260, 1471.

Dr. Neravetla was also evaluated by psychiatrist Dr. Teresa Mulvihill, M.D. at Pine Grove, who diagnosed him with an Occupational Problem and having Obsessive Compulsive traits. AR 1461, Final Order 1.6 at AR 1605. Pine Grove ruled out chemical dependency. Ultimately, the group of evaluators at Pine Grove gave an overall assessment of Occupational Problem (disruptive behavior) and that Dr. Neravetla displayed prominent obsessive-compulsive and narcissistic traits. *Id.*, AR 1475. The evaluators recommended that Dr. Neravetla undergo six weeks of intensive, residential-level treatment before they would consider him safe to return to practice. AR 1476, Final Order 1.7 at AR 1606.

E. Dr. Neravetla's Testimony

At the hearing, Dr. Neravetla testified on his own behalf. As the Commission panel members observed in their Final Order, his problems

with defensiveness and lack of insight were readily apparent to them. Final Order 1.9(b) at AR 1608. His testimony spans approximately 150 pages (AR 2447 to 2600). Dr. Neravetla's testimony demonstrated all the negative aspects of his condition as described by the department's witnesses during his testimony at hearing. Final Order 1.10 at AR 1610. It showed his defensiveness as well as his inability to reconcile the descriptions of others about him versus his own perception of events. Final Order 1.9(b) at AR 1608.

F. Evidence Of Disruptive Physician Behavior

One of the Commission's exhibits at hearing was the Commission's policy statement regarding disruptive behavior. Ex. D-9: MQAC Policy Statement, AR 1831-33. The American Medical Association has defined disruptive behavior as "personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)" *Id.*, 1831-34 (Exhibit D-9). The Commission must place the safety of the public first. RCW 18.130.160. This principle is reflected in their Policy Statement, "[d]isruptive behavior by physicians and physician assistants is a threat to patient safety and clinical outcomes. The Medical Quality Assurance Commission will take appropriate action regarding

practitioners who engage in disruptive behavior." AR 1479, 1832. The Joint Commission[3] describes intimidating and disruptive behaviors as including overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. *Id.* The consequences of disruptive behavior include job dissatisfaction for staff, including other physicians and nurses, voluntary turnover, increased stress, patient complaints, malpractice suits, medical errors, and compromised patient safety. AR 1480, 1833.

Disruptive Physician Behavior is not a new phenomenon. In the past, however, it was not always recognized as having an adverse effect on patient safety or clinical outcomes, and was therefore often tolerated. *Id.* "Today's physicians work in a team environment, and the ability to communicate and cooperate with other members of the health care team is crucial to the delivery of good health care." Final Order 1.10(b) at AR 1610. "When conduct such as inability to work with others, uncooperative attitudes, poor responses to corrective action, confusing communication, etc., rise to the level where multiple independent

[3] The Joint Commission is an independent, not-for-profit organization. The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

professionals conclude there is an occupational problem, then patient care is affected." *Id.* "Such behavior disrupts the effectiveness of team communications and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events." Final Order, n. 6, at AR 1610, citing to the MQAC Policy at AR 1480 and 1833. Dr. Kent Neff, a psychiatrist and recognized expert in the field of disruptive physician behavior describes it as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care." MQAC Policy, at AR 1480 and 1833.

G. Procedural History

1. Commission's Statement Of Charges

On March 18, 2013, the Commission issued a Statement of Charges (SOC) against Dr. Neravetla, asserting that he was unable to practice with reasonable skill and safety pursuant to RCW 18.130.170(1). AR 3-6. The Commission did not charge Dr. Neravetla with violating any provision of RCW 18.130.180 or accuse him of unprofessional conduct. *Id.* Per regular Commission practice, the Commission kept a clean line between charges of incapacity to practice and unprofessional conduct

based on the alleged conduct of Dr. Neravetla. *Compare* 18.130.170(1) (capacity to practice) with RCW 18.130.180 (unprofessional conduct).

The allegations in the Statement of Charges are virtually identical to the facts as set forth above, and as presented at hearing. Contrary to Dr. Neravetla's assertions, the Department's charges were set forth in the original SOC and it was never amended. The SOC specifies that Dr. Neravetla was in a Transitional Year Residency Program from June 2011 to February 2012. He was placed on probation in November 2011 due to concerns about professionalism, accountability, attendance, communication and patient care, and then was referred to WPHP in February 2012 regarding "an alleged pattern of disruptive and unprofessional behavior." SOC 1.2, at AR 3.

The next paragraph (1.3) of the SOC describes Dr. Neravetla's evaluation at WPHP, where he was "defensive, disruptive, hostile, and unwilling and argumentative regarding WPHP staff's recommendation that he obtain a comprehensive evaluation..." AR 3.

Paragraph 1.4 details how MQAC was advised that WPHP could not endorse Dr. Neravetla as safe to practice because of his unwillingness to follow through with the evaluation process and their preliminary diagnosis of a personality disorder. AR 4.

Paragraph 1.5 details Dr. Neravetla's evaluation at Pine Grove and their findings. It specifies their diagnostic impressions of Dr. Neravetla to include "occupation problem/disruptive behavior (Axis I)[4]; prominent obsessive-compulsive and narcissistic traits, rule out Personality Disorder, not otherwise specified, with obsessive-compulsive and narcissistic traits (Axis II); classified as moderate to severe (Axis IV)." AR 4. The evaluation goes on to detail that Pine Grove could not endorse his return to practice until he participated in treatment for his problems. *Id.* Dr. Neravetla filed an Answer wherein he made limited admissions, and denied that there was any basis for the imposition of any sanctions against him. AR 19-23.

The allegations as set forth in the SOC at the beginning of the case were precisely the issues presented at hearing. *See* Prehearing Order No. 11: Order Defining Conduct of Hearing, AR 1562-67.

2. Commission's Final Order

The hearing was held on April 21-23, 2014, before a panel of four members of the Commission. AR 1835-2706. On May 27, 2014, the Commission issued its Final Order. AR 1599-1614. In its Final Order, the

[4] The DSM is the Diagnostic and Statistical Manual of Mental Disorders. It is published by the American Psychiatric Association. The DSM IV assesses five dimensions: Axis I: Clinical Syndromes; Axis 2: Developmental Disorders and Personality Disorders; Axis III: Physical Conditions; Axis IV: Severity of Psychosocial Stressors; and Axis V: Highest Level of Functioning. *See* http://allpsych.com/disorders/dsm/; *See also* Testimony of Ed Anderson at AR 2303-04.

Commission found that Dr. Neravetla had an occupation problem that interfered with his ability to communicate and work with others and that if it persisted, it would impede his ability to practice with reasonable skill and safety. Final Order 1.10(b) at AR 1610. The Commission specifically found that the "Department proved by clear and convincing evidence that the Respondent's ability to practice with reasonable skill and safety was sufficiently impaired by an occupational problem to trigger the application of RCW 18.130.170(1)". Final Order 2.4 at AR 1611. In reaching that decision, the Commission made credibility findings about all the witnesses (Final Order 1.9 at AR 1607-08) and carefully evaluated the case. Final Order 1.10 at AR 1608-10. Further, the Commission specifically rejected Dr. Neravetla's theory of the case that Dr. Dipboye had shaped the diagnosis by providing one-sided and prejudicial collateral information. Final Order 1.10(a) at AR 1609. On June 6, 2014, Dr. Neravetla petitioned for reconsideration. AR 1616-1749. On July 15, 2014, the Commission denied Dr. Neravetla's petition for reconsideration. AR 1775-79. The Final Order was upheld in Superior Court.

IV. STANDARD OF REVIEW

The Administrative Procedure Act "establishes the exclusive means of judicial review of agency action." RCW 34.05.510. The burden of demonstrating the invalidity of agency action is on the party asserting

invalidity. RCW 34.05.570(1)(a). The validity of agency action shall be determined in accordance with the standards of review provided in RCW 34.05.570, "as applied to the agency action at the time it was taken." RCW 34.05.570(1)(b). When reviewing an adjudicative order, a court acts in a limited appellate capacity and may reverse only if the person challenging the agency order establishes that the order is invalid for one of the nine reasons specifically enumerated in RCW 34.05.570(3). Appellate review is confined to the administrative record. *Clausing v. State*, 90 Wn. App. 863, 870, 955 P.2d 394 (1998).

Under the APA, relief is offered under a limited number of enumerated bases detailed in RCW 34.05.570(3)(a) through (i). Dr. Neravetla has neglected to state the specific bases of his appeal. By ruling out those which cannot fit, the Department will address his arguments under the following bases:

> (a) The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied;
> ....
> (d) The agency has erroneously interpreted or applied the law;
>
> (e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;
> ...

> (g) A motion for disqualification under RCW 34.05.425 or 34.12.050 was made and was improperly denied or, if no motion was made, facts are shown to support the grant of such a motion that were not known and were not reasonably discoverable by the challenging party at the appropriate time for making such a motion;
> ....
> (i) The order is arbitrary or capricious.

RCW 34.05.570(3).

V. ARGUMENT

A. The Plain Language Of RCW 18.130.170(1) Captures More Conditions Than Objectively Diagnosable "Mental Disorders"

As the central issue in this appeal, the parties dispute whether RCW 18.130.170(1) is to be construed to capture only objectively diagnosable mental disorders or whether the legislature intended the Commission may, with its expertise, determine whether a physician suffers from a mental condition which impairs his capacity to practice with reasonable skill and safety. Dr. Neravetla argues that the statute has a plain and clear meaning that must be interpreted to limit the term "any mental condition" to mean only those conditions that can be objectively diagnosed as "mental disorders" or "mental health conditions." *See* Appellant's Brief at 31 (distinguishing the DSM-V[5] section on "other conditions and problems" from "mental disorders"). But Respondent's strict interpretation must fail because it ignores legislative intent, avoids

[5] At the time of these events, the DSM-V was not yet in use. Furthermore, as the Final Order explicitly states, the issue before the panel did not hinge on a diagnosis under the DSM. AR 1607.

the ordinary meaning of "mental condition," and leads to an absurd result that hamstrings the Commission's duty to protect the public health and safety from impaired physicians.

1. The Commission's interpretation of RCW 18.130.170(1) to apply to Dr. Neravetla's mental conditions is consistent with language and legislative purposes.

The Court's duty in statutory interpretation is to discern and implement the legislature's intent. Plain meaning may be gleaned from all that the Legislature has said in the statute and related statutes which disclose legislative intent about the provision in question. In construing any statute, courts avoid absurd results. *Lowy v. PeaceHealth*, 174 Wn.2d 769, 779, 280 P.3d 1078 (2012). Courts are not to read into statutes matters that are not there, or modify statutes by construction. *King Cnty. v. City of Seattle*, 70 Wn.2d 988, 991, 425 P.2d 887 (1967).

If a term is defined in a statute, that definition is used. Absent a statutory definition, the term is generally accorded its plain and ordinary meaning unless a contrary legislative intent appears. *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 813, 828 P.2d 549 (1992). Washington courts accord substantial weight to the agency's interpretation of the law, although the court may substitute its judgment for that of the agency. *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 728, 818 P.2d 1062 (1991). Substantial deference to agency views is appropriate when

an agency determination is based heavily on factual matters, especially factual matters that are complex, technical, and close to the heart of the agency's expertise. *Premera v. Kreidler*, 133 Wn. App. 23, 31, 131 P.3d 930 (2006), *as amended on reconsideration* (June 14, 2006).

It is a recognized basic principle that statutes concerning public health and safety should be liberally construed. *Snohomish Cnty. Builders Ass'n v. Snohomish Health Dist.*, 8 Wn. App. 589, 595, 508 P.2d 617 (1973); *Spokane Cnty. Health Dist. v. Brockett*, 120 Wn.2d 140, 149, 839 P.2d 324 (1992). Dr. Neravetla claims to the contrary that the statute affects a liberty interest and should therefore be narrowly construed. That argument for a generous interpretation is antiquated under Washington law and cannot overcome the legislative intent to protect the public. *E.g. Hardee v. State, Dep't of Soc. & Health Servs.*, 172 Wn.2d 1, 8, 256 P.3d 339 (2011).

While "mental condition" is not defined, its meaning is clear from the context of RCW 18.130.170(1), the ordinary meaning of the word, and the understanding of that term within the shared knowledge of physicians. In RCW 18.130.170(1), "mental condition" means a mental condition which impairs the capacity of the physician from practicing with reasonable skill and safety. RCW 18.130.170(1) ("The hearing shall be

limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety".).

This corresponds with the ordinary meaning of "mental condition." According to Webster's Third New International Dictionary (1982), "condition" means, "4: a mode or state of being ... b *obs*: state with reference to mental or moral nature, temperament, character, or disposition ...." The common meaning is broader than "mental disorder" or "mental illness". It can mean mental temperament, mental character, or mental disposition. The legislature used a more general term, "mental condition," in order to allow the Commission to protect the public from a wider variety of impairments of "capacity" to practice than just mental disorders. *See In re Ryan*, 97 Wn.2d 284, 288, 644 P.2d 675 (1982) ("other mental incapacity" in attorney discipline rule was best way to capture necessarily broad array of mental conditions). Moreover the statute's use of the modifier "any" and the principle of liberal construction of health and safety statutes further reinforce the breadth of meaning the legislature intended the term to carry.

The purposes of the Commission and the powers granted to it also reinforce its interpretation of RCW 18.130.170(1). The Commission was created in part because "the conduct of members of the medical profession licensed to practice medicine and surgery in this state plays a vital role in

preserving the health and well-being of the people of the state". RCW 18.71.003(3) (declaration of purpose). The legislature "intends to increase the authority of those engaged in the regulation of health care providers to swiftly identify and remove health care providers who pose a risk to the public." Laws of Washington 2008, c. 134, § 1. Thus, the legislature intends for the Commission to interpret terms like "any mental condition" using the shared knowledge of the profession. *See Haley*, 117 Wn.2d at 720 ("moral turpitude" defined in part by shared knowledge of physicians). This gives the Commission latitude to identify physicians who endanger the public through their lack of capacity to practice with reasonable skill and safety and to issue sanctions necessary to protect the public.

Thus, a plain reading of RCW 18.130.170(1) does not restrict the Commission to finding a mental disorder or disability. To substitute "disorder" for "condition," as Dr. Neravetla's argument suggests, would ignore the plain language of the statute and thwart the legislature's intent in enacting it: to protect the public when there is a question of the physician's ability to practice safely due to *any* mental condition. This Court does not read words into a statute which are not there. *King Cnty. v. City of Seattle*, 70 Wn.2d at 991.

In sum, Dr. Neravetla's redefinition of "any mental condition" to exclude his mental condition contradicts the plain language, ordinary meaning, and intent of the statute. It would restrict the Commission from dealing with the wide array of mental conditions in the physician community which may not be objectively diagnosable as a mental disorder but which nevertheless impair the physician's capacity to practice with reasonable skill and safety. To so hamstring the Commission's ability would endanger the public and profession. The Court should reject Dr. Neravetla's interpretation.

2. The Commission did not conflate RCW 18.130.170(1) with RCW 18.130.180.

The Commission explicitly charged Dr. Neravetla under RCW 18.130.170(1). AR 5. RCW 18.130.180 has never been at issue in this case. As explained above, the legislature specifically separated charging conduct which demonstrates impaired capacity from conduct by an unimpaired physician which violates professional standards.

The fact that conduct, instead of diagnosis and disorder, was alleged and presented in order to prove Dr. Neravetla's impaired mental condition did not conflate the charges with unprofessional conduct. Both charges under RCW 18.130.180 and 18.130.170(1) may be established by findings based entirely on allegations of conduct and expert testimony.

The difference is one of substance and policy, whether to hold the physician directly accountable for bad acts or to place inappropriate conduct or bad acts within the rubric of a mental condition or impairment. Dr. Neravetla contends that charging him under RCW 18.130.170(1) confused and misled him in preparing his defense. He asserts that he should have only had to offer expert testimony that he had been evaluated and was not objectively diagnosable as suffering from a mental disorder. But this argument relies on his misguided, unduly narrow, and unreasonable interpretation of RCW 18.130.170(1), discussed just above. It should therefore be rejected. The legislature intended the Commission to have the authority to exercise its expertise to remove from practice those physicians who, due to any mental condition, lack the capacity to safely practice.

B. RCW 18.130.170(1) Is Not Unconstitutionally Vague And Dr. Neravetla Was Not Deprived Of Sufficient Notice Of The Charges Against Him

Dr. Neravetla challenges the constitutionality of RCW 18.130.170(1), as allowed by RCW 34.05.570(3)(a). Specifically, he argues that the statute as interpreted and applied in the Commission's Final Order is unconstitutionally vague. He also challenges the charging document as vague, thereby depriving him of due process. The Court should reject his argument because the statutory provision is well defined

when read with the statute as a whole and applied by the Commission with the shared knowledge of the medical profession.

A statute is presumed to be constitutional, although an unduly vague statute can deny a person due process. *Haley*, 117 Wn.2d at 739. The party challenging a statute's constitutionality on vagueness grounds has the burden of demonstrating its vagueness beyond a reasonable doubt. *Haley*, 117 Wn.2d at 739.

A statute is void for vagueness only if it is framed in terms so vague that persons of common intelligence must necessarily guess at its meaning and differ as to its application. *Haley*, 117 Wn.2d. at 739. "A statute is not unconstitutionally vague merely because a person cannot predict with complete certainty the exact point at which his actions would be classified as prohibited conduct." ¶*Haley*, 117 Wn.2d at 740 (internal quotation omitted). "The purpose of the vagueness doctrine is to ensure that citizens receive fair notice as to what conduct is proscribed, and to prevent the law from being arbitrarily enforced." *Id.* at 739-40.

In a vagueness challenge, courts do not analyze portions of a statute in isolation from the context in which they appear. If a statute can be interpreted so as to have the required degree of specificity, then it can withstand a vagueness challenge despite its use of a term which, when considered in isolation, has no determinate meaning. *Haley*, 117 Wn.2d at

741. Moreover, Washington courts have long endorsed the principle that, "where the language of a statute fails to provide an objective standard by which conduct can be judged, the required specificity may nonetheless be provided by the common knowledge and understanding of members of the particular vocation or profession to which the statute applies." *Haley*, 117 Wn.2d at 743 (internal quotation omitted).

When the plain language of RCW 18.130.170(1) is read with the statutory scheme as a whole, using the meaning of the statute's terms as understood within the medical profession, the statute is not unconstitutionally vague. This is demonstrated by a very analogous medical disciplinary case. *Haley*, 117 Wn.2d 720.

In *Haley*, the term "moral turpitude" in RCW 18.130.180(1) was challenged as unconstitutionally vague. The statute states in pertinent part that unprofessional conduct is violated by, "(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not." RCW 18.130.180(1). The *Haley* Court agreed that the term might be vague if read in isolation. However, the Court rejected the vagueness challenge on the basis that the term is to be understood by its context.

"Moral Turpitude" derived concrete meaning from the context of the purposes of professional discipline as demonstrated in the statutory

framework, in a specific application, and with the shared knowledge and understanding of the medical profession:

> When RCW 18.130.180(1) is construed in relation to the purposes of professional discipline, considered in the context of a specific application, and supplemented by the shared knowledge and understanding of medical practitioners, its content is sufficiently clear as to put persons of common understanding on notice that certain conduct is prohibited. Physicians no less than teachers, as in *Morrison*, veterinarians, as in *Hand*, or police officers, as in *Cranston*, will be able to determine what kind of conduct indicates unfitness to practice their profession.

Haley, 117 Wn.2d at 743.

Another analogous disciplinary action by the Bar Association further reinforces this analysis. *In re Ryan*, 97 Wn.2d at 284. Mr. Ryan, a young attorney, was put on inactive status after he engaged in a series of delusional and paranoid behaviors concerning his legal practice, including some court filings which were contrary to his client's interest. He was transferred to inactive status under a disciplinary rule requiring restriction from practice due to "insanity, mental illness, senility, excessive use of alcohol or drugs, or other mental incapacity. DRA 4.1(b)." *In re Ryan*, 97 Wn.2d at 288. One psychiatrist concluded that Ryan had experienced a full-blown paranoid delusion and that he was not capable to practice. But Ryan was not diagnosed with any disorder or mental illness. Rather, the disciplinary officer relied on the testimony of Ryan's colleagues and

friends that he was suffering from a "mental problem" to find that he was incapable of practicing law due to having an "unstable mental state." *Id.* at 287. He also found that Ryan's own testimony supported the allegations as he still had no insight into the unstable nature of his actions. *Id.* at 287-88.

On appeal, Ryan challenged the terms "mental illness" and "other mental incapacity" as unconstitutionally vague. The Court disagreed, based on the rest of the statutory language modifying those terms:

> Ryan overlooks, however, the qualifying condition of the rule; that the mental condition must cause the attorney to be unable to conduct his/her law practice adequately. DRA 4.1(b). Thus, the Bar must establish that an attorney is unable to conduct the practice of law adequately because of insanity, mental illness, senility, excessive use of alcohol or drugs, or other mental incapacity. DRA 4.1(b). Given the inherently uncertain nature of mental illness and the broad ranges of the practice of law, we fail to perceive how a more definite standard could be articulated, and Ryan has suggested none.

Ryan, 97 Wn.2d at 287-88. Despite the lack of any diagnosis or more objective mental illness, the Court upheld Ryan's discipline under the rule.

RCW 18.130.170(1) similarly does not suffer from vagueness because the rest of the language in the statute clarifies the type of mental condition intended: that the mental condition must cause the physician to be unable to practice with reasonable skill and safety. And, like the attorney disciplinary rule, there is no more narrow way to define "mental

condition" and still capture those types of impairment which may render a physician unsafe to practice. *See also State v. Pacific Health Center, Inc.*, 135 Wn. App. 149, 143 P.3d 618 (2006) (definition of "practice of medicine" in RCW 18.71.011 is not ambiguous or vague, despite containing phrase "or other condition, physical or mental", when read in context and with common understanding of terms). *Haley* and *Ryan* together show how the term "any mental condition" is not vague as used in the statute and context of professional discipline. As in *Haley* and *Ryan*, this Court should reject Dr. Neravetla's argument that he has demonstrated the Commission's application of RCW 18.130.170(1) to be unconstitutionally vague beyond a reasonable doubt. He has not met his burden for relief under RCW 34.05.570(3)(a).

Similarly, Dr. Neravetla's argument that he did not receive constitutionally adequate notice of the charges against him should fail. Dr. Neravetla argues that the statement of charges was unconstitutionally vague under constitutional due process notice requirements such that he could not discern whether to mount a defense that he did not suffer from a diagnosable mental disorder or whether to contest the allegations regarding his conduct as a resident. But his confusion does not derive from any vagueness in the statute or charging document.

Dr. Neravetla's contention that he failed to understand the charges against him does not mean he was insufficiently put on notice to satisfy due process requirements. As previously described, the SOC was clear. He was further put on notice by the Department's Response to and the Court's Order on Summary Judgment. AR 1158 and 1535. Instead, Dr. Neravetla failed to read the statute in its statutory context with the shared knowledge of his profession. For instance, the Commission, other medical disciplinary bodies from other jurisdictions, and courts have considered physician disruptive behavior occupational problems to constitute impaired mental conditions within the meaning of the statute. *E.g. Leal v. Secretary. U.S. Dept.of Health and Human Services*, 620 F.3d 1280, 1283-84 (11th Cir. 2010) ("Disruptive and abusive behavior by a physician, even if not resulting in actual or immediate harm to a patient, poses a serious threat to patient health or welfare."). Furthermore, the existence of the Commission policy on disruptive physician behavior gives notice that the Commission had dealt with physician disruptive behavior in so many situations that it created an interpretive policy to advise the profession regarding its problematic nature. (Exhibit D-9; AR 1831-34.)

Dr. Neravetla also argues that he was misled and confused by the Commission's charge that he suffered from a mental condition in addition to its allegations of specific conduct. Dr. Neravetla states that he

concentrated his defense at hearing to contest that he could not be diagnosed with any objectively established mental disorder. However, the choice of that defense is merely strategic, not born of confusion. Dr. Neravetla was provided with the Department's exhibits early in this case. His attorneys deposed all of the Department's witnesses. He was well aware long before the hearing of the actual mental condition at issue, which is determined by a physician's conduct, rather than psychological testing instruments. *See* AR 2257-58, testimony of Dr. Anderson (diagnostic testing not that useful in physician disruptive behavior cases in his 13 years of dealing with the condition). Further, framing the hearing in such a way would have allowed Dr. Neravetla to emphasize the testimony of experts who had access only to the information which Dr. Neravetla had chosen to provide them, not the collateral information that the Department's experts opined was necessary for a complete evaluation. When dealing with disruptive physician behavior, the actions in the workplace are crucial to the evaluation. As Dr. Anderson testified, "the focus of the evaluation on disruptive behavior is disruptive behavior." AR 2258.

In sum, Dr. Neravetla's challenge to insufficient notice is premised on his failed vagueness challenge to the statute. The Court should reject

his challenge. There is no constitutional infirmity in the statute or the Commission's interpretation or application of the statute.

C. The Record Contains Substantial Evidence That Dr. Neravetla Is Unable To Practice With Reasonable Skill and Safety

An agency's findings of fact are reviewed under the "substantial evidence" standard. RCW 34.05.570(3)(e). Under this standard, a court will uphold an agency's finding of fact if it is "supported by evidence that is substantial when viewed in light of the whole record before the court". RCW 34.05.570(3)(e). The courts have described "substantial evidence" as "evidence in sufficient quantum to persuade a fair-minded person of the truth of the declared premises". *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 607, 903 P.2d 433, 439 (1995) (internal quotes and citations omitted). Evidence will be viewed in the light most favorable to "the party who prevailed in the highest forum that exercised fact-finding authority." *City of Univ. Place v. McGuire*, 144 Wn.2d 640, 652, 30 P.3d 453, 459 (2001). In viewing the evidence in the light most favorable to the prevailing party, this "necessarily entails acceptance of the factfinder's views regarding the credibility of witnesses and the weight to be given reasonable but competing inferences." *Id.*

Dr. Neravetla contends that "there was no legitimate, much less substantial, evidence presented that Dr. Neravetla could not practice with

reasonable skill and safety." Appellant's Brief at 39. He supports this contention only with the bare bones assertion that no patients were actually injured during his residency. He neglects to cite to any particular findings in the Final Order that are not supported. An appellate court need only review findings of fact to which error has been assigned. *State v. Hill*, 123 Wn.2d 641, 647, 870 P.2d 313 (1994); RAP 10.3(g), (h). Dr. Neravetla's contention is both unsupported and without merit.

There is substantial evidence to support the Commission's findings of fact, which are reviewed for substantial evidence, and unchallenged findings are treated as verities on appeal. *Darkenwald v. State Employment Sec. Dep't*, 183 Wn.2d 237, 350 P.3d 647, 650 (2015). The Department presented testimony from seven professionals about Dr. Neravetla's condition. First, there was testimony from Dr. Dipboye, the Transitional Year Residency Director about what he observed regarding Dr. Neravetla. Next, Dr. Owens, the Director of Medical Education, testified about his interactions with Dr. Neravetla. Dr. O'Connell, the psychologist who attempted to "coach" Dr. Neravetla when he was struggling at VMMC also testified. The Department also presented the testimony of both Dr. Meredith and Mr. Green, mental health professionals from WPHP, about their interactions and observations of Dr. Neravetla. Finally, Dr. Anderson and Dr. Mulvihill from Pine Grove

testified about their observations and evaluation of Dr. Neravetla. Notably, Pine Grove specializes in evaluating and treating health care professionals for various vocational, occupational, mental health, and substance abuse issues. AR 2239. The professionals at Pine Grove do approximately 80 comprehensive evaluations of healthcare professionals each year. AR 2240. And the WPHP selects the centers nationwide that they have determined have the most experience in dealing with disorder presentation and occupational problems, centers that use a multidisciplinary team like Pine Grove does and that see a significant number of cases like this one each year. AR 2120-21.

In addition, the panel reviewed exhibits that fully corroborated the testimony of those seven witnesses (Exhibits 2-8). Further, the MQAC Policy Statement, which explained the condition of Disruptive Physician Behavior and why such behavior implicated the capacity of a healthcare provider to practice with reasonable skill and safety, was provided as an exhibit. AR 1831-34, Ex. D-9.

Dr. Meredith's testimony explained the ways in which disruptive behavior can jeopardize patient care and safety. AR 2113. One of the scenarios he described was that "if we have a member of a physician team that bullies individuals or engages repeatedly in intimidating, verbal, threatening behavior, they are essentially going to be avoided by other

members of the healthcare team...They're going to be afraid to approach that individual..." *Id.* This indeed jeopardizes patient safety. As indicated in the Final Order and the MQAC Policy, "[t]he importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasingly evident. Such behavior disrupts the effectiveness of team communications and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events." AR 1610. In fact, the Patient Safety Alert that was issued due to communication issues that involved Dr. Neravetla demonstrates how disruptive physician behavior can impact patients. AR 1962, 1964. Patients should not be placed at risk because their doctor refuses to communicate with another member of the health care team.

In short, Dr. Neravetla does not identify any specific findings that lack substantial evidence and, as shown above, substantial evidence supports the Commission's factual findings. And those findings supported the conclusions of law and judgment. The Commission's Final Order should therefore be upheld.

D. The Commission's Final Order Was Neither Arbitrary Nor Capricious And Therefore Did Not Violate RCW 34.05.570(3)(i)

Dr. Neravetla asserts that the panel's decision was arbitrary and capricious because it "disregarded the testimony of all of his experts." Appellant's Brief at p. 43. His assertion is meritless and misdirected.

The scope of court review is very narrow when appraising agency action for arbitrary and capricious decisions. *Pierce Cnty. Sheriff v. Civil Serv. Comm'n of Pierce Cnty.*, 98 Wn.2d 690, 695, 658 P.2d 648, 651 (1983). The party who seeks to demonstrate that an action is arbitrary and capricious carries a heavy burden. *Id.* Arbitrary and capricious action is defined as willful and unreasoning action, without consideration and in disregard of facts and circumstances. Where there is room for two opinions, action is not arbitrary and capricious even though the reviewing court may believe an erroneous conclusion has been reached. *Pierce Cnty. Sheriff v. Civil Serv. Comm'n of Pierce Cnty.*, 98 Wn.2d at 695. Harshness is not the test for arbitrary and capricious action. *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 609, 903 P.2d 433, 440 (1995).

If the administrative agency has acted honestly, with due deliberation, within the scope of and in furtherance of its statutory and constitutional functions, and has been neither arbitrary, nor capricious, nor unreasonable, then there is nothing left for the courts to review.

Deaconess Hosp. v. Washington State Highway Comm'n, 66 Wn.2d 378, 406, 403 P.2d 54, 70 (1965).

The Commission's Final Order was a well-reasoned decision supported by substantial evidence in the record. The Commission heard and considered the testimony of Dr. Neravetla's three experts. While it found their testimony to be credible, the Commission gave their testimony little weight because it focused on ruling out a disorder diagnosis, rather than addressing the critical issue before the Commission: whether Dr. Neravetla suffered from a mental condition. AR 1608, Final Order ¶1.9(c); *see also* RCW 18.130.170(1). Also, contrary to Dr. Neravetla's assertions, Dr. Meredith never testified that disruptive physician behavior is not a mental condition. (App. Br. at 30). Instead, Dr. Meredith testified that it was not a diagnosis under the DSM. The record demonstrates that Dr. Meredith and his colleagues at WPHP were very concerned about Dr. Neravetla's mental condition, as they referred him for further evaluation and contacted MQAC when they believed he was not going to go. AR 2130. Dr. Meredith also testified that he agreed with the diagnostic impressions of Pine Grove. AR 2136. As Dr. Anderson explained to the panel, the DSM (Diagnostic and Statistical Manual of Mental Disorders) acknowledges that "mental disorders" is a difficult and somewhat vague term. Further, the DSM has a cautionary statement that not everything

that is a focus of clinical attention falls under the category of mental disorders; that there are other conditions that may be the focus of clinical attention, like occupational problems. AR 2303. Dr. Anderson offered the example of a physician who is having sex with patients. He may not have a mental disorder, but he has an occupational problem that needs clinical attention, just as a disruptive doctor does. AR 2304.

Additionally, the Commission had ample reason when it discounted Dr. Neravetla's experts. They evaluated him without any contact with the collateral sources from either VMMC or WPHP, and with the sole intent of ruling out a psychiatric or personality disorder. Final Order 1.9(c) at AR 1608. As indicated above, any evaluation lacking contact with collateral sources is inadequate and incomplete. AR 1499. Therefore, this is not a situation where the Commission disregarded the facts and took unreasonable action. The Commission reasonably considered all the evidence and determined which of the witnesses and evidence was more compelling, and then issued its ruling. The Commission noted several times in its order that "a respondent does not have to have fit into any particular type of diagnostic label peghole to trigger RCW 18.130.170(1)." AR 1607-08, Final Order 1.9, at footnotes 4, 5. Thus, the Commission was justified in giving Dr. Neravetla's experts' opinions less weight. Dr. Neravetla and his experts all

focused on the lack of a mental disorder diagnosis, and ignored the obvious mental condition diagnosis.

Moreover, even his own expert, Dr. Eth, conceded that Dr. Neravetla had the mental condition of an occupational problem. AR 2660-62. He said, "He didn't have a mental disorder, he had a mental condition of a problem that he was contending with." AR 2660. And in response to whether or not disruptive physician behavior equates to a mental condition he said, "It may. It may be symptomatic of a – of certain psychiatric disorders." AR 2661. Dr. Eth also testified that a mental condition would be diagnosed from symptoms and then he conceded that as to Dr. Neravetla there were descriptions of inappropriate behavior. AR 2661-62. The Commission found that Dr. Eth agreed that Dr. Neravetla had an occupational problem, and that occupational problem was the precise reason that the Commission found Dr. Neravetla unsafe to practice. Final Order n.4 at AR 1607, 1.10 at AR 1609.

Dr. Neravetla also argues that hearsay should not have been permitted and that testimony about his behaviors should not have been admitted at the hearing. Petitioner's App. Br. p. 40-43, 37-39. This is misdirected. What was made clear by experts Dr. Anderson and Dr. Meredith, and affirmed by Dr. Neravetla's expert, Dr. Eth, is that

disruptive physician behavior is evaluated and "diagnosed" by the physician's behavior.

Notably, the Commission gave a fair amount of weight to Dr. Neravetla's testimony. The Commission found his testimony to be

> "an honest representation of the difficulty he had in tracking the Commission's questions; the difficulty, if not the impossibility, he had of reconciling the descriptions of others about him versus his own experience of events when he is under stress; and the dramatic difference in his ability to articulate in great detail events or areas that interest him and the bleakness of his recollection of areas or events that he felt defensive about. To the extent that these themes contributed to the diagnosis of occupational problem, they are still evident."

Final Order, 1.9(b) at AR 1608. In fact, throughout his testimony, Dr. Neravetla was consistently unable to accept or discuss any negative feedback of his performance at VMMC, but, in stark contrast, readily testified about positive aspects about himself and the work he has done. Final Order 1.9(b) at AR 1608, *See also* testimony of Respondent at AR 2460-61, 2472-73, 2476-78 2516, 2587-91, 2597-98. Dr. Neravetla's testimony was consistent with the descriptions from Dr. Meredith, Mr. Green, and Dr. Anderson about how Dr. Neravetla presented to them. It was also consistent with how disruptive providers tend to blame the system and others, but lack the self-scrutiny and ability to reflect on their own behavior and discuss their own contributions to the problem and to

take responsibility for their role in creating the predicament that they are in. AR 2251.

In sum, the Final Order demonstrates that the Commission considered the testimony of Dr. Neravetla as well as all of the expert testimony, made credibility determinations, and articulated the weight to be given to such testimony. The fact that the Commission found the Department's experts more persuasive than Dr. Neravetla's experts and gave the former more weight is reasonable and appropriate in light of the totality of the evidence. Dr. Neravetla fails to meet the narrow, high bar to claim that his evaluation of evidence was arbitrary and capricious action.

As to Dr. Neravetla's claim that the accuracy of the collateral information was unverified (App. Br. at p. 19-20), this argument is also without merit. Although the Presiding Officer limited the amount of testimony regarding Dr. Neravetla's behavior at VMMC to only that which went directly to his mental condition and ability to practice safely, Dr. Neravetla nevertheless objects to the admission of even that limited evidence. Had the Presiding Officer, however, allowed each of the VMMC doctors to testify to corroborate the testimony of Dr. Dipboye, additional evidence regarding Dr. Neravetla's behavior at VMMC would have been presented and made part of the record. Further, the problems described by Dr. Dipboye were corroborated by each of the Department's

witnesses: Dr. Owens, Dr. O'Connell, Dr. Meredith, Mr. Green, Dr. Anderson, and Dr. Mulvihill, who all interacted with Dr. Neravetla and found him to be difficult and disruptive. Further, as the Commission articulated in its final Order, panel members also observed that behavior when Dr. Neravetla testified. *See* Final Order, p. 8, at AR 1608.

E. The Appearance Of Fairness Doctrine, As Set Out In RCW 34.05.570(3)(g), Was Not Violated

Dr. Neravetla claims that the Presiding Officer improperly refused to disqualify one of the panel members, Dr. Green, M.D., a former physician at VMMC. (App. Br. at 47.) This claim also lacks merit.

The appearance of fairness doctrine applies to both administrative decision-makers as well as judicial officers. The same due process requirements apply, requiring that judicial officers be free of any taint of bias. The appearance of fairness doctrine provides protection against decision-makers who are actually biased or have a pecuniary interest in the proceedings. *City of Lake Forest Park v. State of Washington Shorelines Hearings Bd.*, 76 Wn. App. 212, 217, 884 P.2d 614 (1994). The test to determine whether the appearance of fairness has been violated is whether a disinterested person with knowledge and understanding of all the facts would conclude a party did not receive a fair, impartial and neutral hearing. *Id.* at 217; *Magula v. Dep't of Labor and Industries*, 116 Wn. App. 966, 973, 69 P.3d 354 (2003). A person claiming an

appearance of fairness violation is required to present specific evidence of a violation, not speculation. The presumption is that administrative decision-makers perform their quasi-judicial functions properly. *City of Lake Forest Park*, 76 Wn. App. at 217; *Magula*, 116 Wn. App. at 972.

The legal standard for disqualification of administrative decision-makers is the same as that for judicial officers. RCW 34.05.425(3). The person whose disqualification is sought determines whether to grant the request, stating facts and reasons for the determination. RCW 34.05.425(5). On review, the court is to accept the administrative fact finder's views on disqualification giving credence to the fact finder's views regarding credibility of witnesses and weight to be given to reasonable but competing inferences. *City of University Place v. McGuire*, 144 Wn.2d 640, 652, 30 P.3d 453 (2001).

There are three types of bias which call for disqualification in quasi-judicial proceedings: (1) prejudgment about issues of fact in the case; (2) partiality showing a personal bias or prejudice for or against a party separate from the issues in the case; or (3) an interest by which the decision-maker stands to gain or lose by a decision either way. *Ritter v. Bd. of Comm'rs of Adams Cy. Public Hospital Dist. No. 1*, 96 Wn.2d 503, 512, 637 P.2d 940 (1981). Neither a judge nor an administrative decision-maker is presumed to be biased. *Id.* at 513. If no specific facts show the

decision-maker was prejudiced or failed to decide the case based upon the evidence presented at hearing, there is no basis for disqualification.

The Presiding Officer conducted a proper inquiry on the record prior to starting the hearing. AR 1886-88. Dr. Green stated that he did not have any concerns about his ability to remain impartial. AR 1887. He also confirmed that his knowledge of any of the potential witnesses from VMMC was limited to occasional paths crossing in the work setting, and that he had no personal dealings with any of them. *Id.* Dr. Green agreed that if at any time he had concerns about his ability to remain impartial, he would notify the parties and the Presiding Officer. AR 1888. Nothing more was required by law. Dr. Neravetla has failed to show that Dr. Green was biased in any way and/or should have been disqualified from serving on the hearing panel. RCW 34.05.425(5), 34.05.570(3)(g).

F. The Evidentiary Rulings Were Proper And Legally Supported

Dr. Neravetla claims that "the Presiding Officer made decisions that were legal error, not based on substantial evidence, and/or arbitrary and capricious." App. Br., at 48-49. In support of his claim, he notes that his Motion for Summary Judgment was denied and that the Presiding Officer improperly excluded exhibits and witnesses. These arguments are meritless.

The court reviews a trial judge's evidentiary rulings for abuse of discretion. *See Univ. of Washington Med. Ctr. v. Washington State Dep't of Health*, 164 Wn.2d 95, 104, 187 P.3d 243, 246 (2008), and *King Cnty. Pub. Hosp. Dist. No. 2 v. Washington State Dep't of Health*, 178 Wn.2d 363, 372, 309 P.3d 416, 421-22 (2013).

1. Exhibits

Dr. Neravetla argues that the Presiding Officer should have admitted exhibits that were offered for the first time at the hearing. His argument lacks merit.

Under the Rules of Evidence, "[e]rror may not be predicated upon a ruling which admits or excludes evidence unless a substantial right of the party is affected." ER 103(a). *Id.* The law gives considerable discretion to administrative law judges to determine the scope of admissible evidence. *Univ. of Washington Med. Ctr.*, 164 Wn.2d 104.

Dr. Neravetla shows no abuse of discretion. In fact, the exhibits at issue were documents never identified in his Prehearing Memorandum or at any other time prior to the day of the hearing. The law is clear on this point: "[d]ocumentary evidence not offered in the prehearing conference **shall not** be received into evidence at the adjudicative proceeding in the absence of a clear showing that the offering party had good cause for failing to produce

the evidence at the prehearing conference." (Emphasis added.) WAC 246-11-390. Dr. Neravetla articulated no good cause for his failure to produce the evidence at the prehearing conference, even though all of the witnesses and exhibits he offered on the day of the hearing were known to him well in advance.

Dr. Neravetla had numerous opportunities to identify his exhibits and seek to have them admitted at appropriate times, and he failed to do so. First, in his Prehearing Memorandum detailing any exhibits to be offered at the hearing, he asserted "Respondent reserves the right to offer exhibits by way of rebuttal, as appropriate and responsive to evidence presented by the government." AR 1380. There was no reference in his Prehearing Memorandum to any of the expert reports he now complains were unfairly excluded. A second opportunity to offer the exhibits came at the Prehearing Conference, when the Presiding Officer asked about the prehearing statement and the lack of exhibits other than potential rebuttal exhibits. Dr. Neravetla's attorneys affirmed that they had no exhibits. AR 1733 and 1739. Third, the Presiding Officer raised the issue at hearing right before Dr. Neravetla presented the testimony of his experts. Even though Dr. Neravetla had not offered the exhibits at the prehearing as required, the Presiding Officer stated he might be willing to admit them at that point. AR 2601-03. Dr. Neravetla's counsel, Mr. Lazarus, again declined the offer. AR 2603.

Accordingly, after three declined opportunities to offer the exhibits at times that would have been reasonable—before the authors of the respective reports testified—the Presiding Officer correctly excluded the previously undisclosed exhibits on the day of the hearing, offered only after the witnesses (authors of the exhibits) had testified and been excused. This issue was also addressed in the Final Order, at footnote 1, at AR 1603.

2. Witnesses

Dr. Neravetla also claims that the Presiding Officer abused his discretion when he denied a proposed witness's testimony, specifically, chief resident Dr. John Roberts, who had not been previously identified. As the Presiding Officer properly determined, however, Dr. Roberts' intended testimony did not meet the definition of rebuttal. AR 2364.

3. Motion for Summary Judgment

A denial of summary judgment cannot be appealed following a trial if the denial was based upon a determination that material facts are in dispute and must be resolved by the trier of fact. *Johnson v. Rothstein*, 52 Wn. App. 303, 759 P.2d 471 (1988). Once a determination is made, rightly or wrongly, that there are issues of fact that can be resolved only after a full hearing, the summary judgment procedure has no further relevance. *Id.* at 305, citing to *Morgan v. American Univ.*, 534 A.2d 323, 327 (D.C. App. 1987).

Dr. Neravetla has not shown any abuse of discretion or how a substantial right of his was affected. His claim should therefore fail.

G. Dr. Neravetla's Argument That The Final Order Is Impossible For Him To Comply With Is Unsupported By Any Evidence

Dr. Neravetla asserts that in order to satisfy the Final Order in this case he must (1) obtain another residency position and (2) obtain that position in Washington. App. Br. at 45-47. His assertion is unsupported by any evidence in the record and is an absurd reading of the Commission's Final Order.

Dr. Neravetla is currently in compliance with the Order. The Order does not require Dr. Neravetla to perform any action unless and until he decides that he wants to return to practice in Washington. The triggering event for any action required by the Order is his application for Washington licensure. Dr. Neravetla therefore remains in compliance with the order so long as he does not return to practice in Washington.

Dr. Neravetla's assertion that he cannot obtain licensure in other states because of the Order is neither supported by evidence nor contrary to law. Final Commission orders in Washington must be reported to the National Practitioner Database as required by federal law. 42 U.S.C. § 11101 et seq. Congress created the Data Bank, finding "a national need to restrict the ability of incompetent physicians to move from State to State

without disclosure or discovery of the physician's previous damaging or incompetent performance." *Leal*, 620 F.3d at 1283-84, quoting 42 U.S.C. § 11101. Dr. Neravetla fails to understand that the Order will not be expunged from his record even if he returns to Washington and successfully obtains licensure.

Dr. Neravetla is not faced with impossibility of compliance, but rather his perceived fear of stigma or the warning the Order gives to other states regarding his condition and unwillingness to engage in treatment for it. But that is what Congress intended by creating the Data Bank. Further, Dr. Neravetla has not provided any evidence, any denied application, Board letter, or rejection notice to support his assertion that he cannot obtain licensure and that his career has been halted because of the Commission's Final Order. The Court should reject this contention.

VI. CONCLUSION

Dr. Neravetla, while still a student, showed clearly that he was not ready to graduate and begin practice as a fully licensed doctor. VMMC acted prudently to try to get him help. WPHP also acted prudently to get him help. The Commission took the only reasonable action available to it, once Dr. Neravetla refused to accept the help offered to him. For the

above stated reasons, the Commission's Final Order should be affirmed in all respects.

RESPECTFULLY SUBMITTED this 24th day of June, 2016.

ROBERT W. FERGUSON
Attorney General

TRACY L. BAHM, WSBA No. 22950
THOMAS E. GRAHAM, WSBA No. 41818
Assistant Attorneys General
Attorneys for Respondent
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

NO. 48394-7

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

SHANTANU NERAVETLA, M.D.,

Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

CERTIFICATE OF SERVICE

I declare under penalty of perjury under the laws of the state of Washington that on June 24, 2016, I served a true and correct copy of the *Brief of Respondent* and this *Certificate of Service* by e-mail and by placing same in the U.S. mail via state Consolidated Mail Service to:

Shawna L. Parks, Law Office of Shawna L. Parks
4470 W Sunset Blvd Ste 107-347
Los Angeles CA 90027
sparks@parks-law-office.com

Michael C. Subit, Frank Freed Subit & Thomas LLP
705 Second Ave Ste 1200
Seattle WA 98104
msubit@frankfreed.com

DATED this 24th day of June, 2016, at Olympia, Washington.

Darla Aumiller
DARLA AUMILLER
Legal Assistant

ORIGINAL

ATTACHMENT A

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

May 23, 2014

Lish Whitson
Attorney at Law
2121 5th Ave
Seattle, WA 98121

Adam Webber
Falke & Dunphe LLC
30 Wyoming Street
Dayton, OH 45409

Kenneth Lazarus
Lazarus & Associates
1025 Thomas Jefferson St NW
Suite 110-G
Washington DC 20007

Tracy Bahm, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100

RE: Shantanu Reddy Neravetla
Master Case No. M2012-1261

Dear Parties:

Enclosed please find Declaration of Service by Mail and Findings of Fact, Conclusions of Law, and Final Order dated May 20, 2014.

Any questions regarding the terms and conditions of the Order should be directed to Mike Kramer, Compliance Officer at (360) 236-2781.

Sincerely,

Michelle Singer

Michelle Singer, Adjudicative Clerk
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

cc: Shantanu Reddy Neravetla, MD, Respondent
Dani Newman, Case Manager
Mike Kramer, Compliance Officer
James McLaughlin, Staff Attorney

Enclosure

H:\ORDER - Combo.doc

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	)	
	)	Master Case No. M2012-1261
SHANTANU REDDY NERAVETLA	)	
Credential No. MDRE.ML.60229618	)	DECLARATION OF SERVICE
Respondent.	)	BY MAIL
	)	
	)	

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

On May 23, 2014, I served a true and correct copy of the Findings of Fact, Conclusions of Law, and Final Order, signed by the Panel Chair on May 20, 2014, by placing same in the U.S. mail by 5:00 p.m., postage prepaid, on the following parties to this case:

Lish Whitson
Attorney at Law
2121 5th Ave
Seattle, WA 98121

Adam Webber
Falke & Dunphy LLC
30 Wyoming Street
Dayton, OH 45409

Kenneth Lazarus
Lazarus & Associates
1025 Thomas Jefferson St NW
Suite 110-G
Washington DC 20007

Shantanu Neravetla, MD
c/o Lish Whitson
2121 5th Ave
Seattle, WA 98121

Tracy Bahm, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100

DATED: This 23rd day of May, 2014.

Michelle Singer, Adjudicative Clerk Office
Adjudicative Clerk

cc: Dani Newman, Case Manager
Mike Kramer, Compliance Officer
James McLaughlin, Staff Attorney

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

May 27, 2014

Lish Whitson
Attorney at Law
2121 5th Ave
Seattle, WA 98121

Adam Webber
Falke & Dunphy LLC
30 Wyoming Street
Dayton, OH 45409

Kenneth Lazarus
Lazarus & Associates
1025 Thomas Jefferson St NW
Suite 110-G
Washington DC 20007

Tracy Bahm, AAG
Colin Caywood, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100

RE: Master Case No. M2012-1261

Dear Parties:

Enclosed please find Declaration of Service by Mail and Findings of Fact, Conclusions of Law, and Final Order dated May 20, 2014.

Any questions regarding the terms and conditions of the Order should be directed to Mike Kramer, Compliance Officer at (360) 236-2781.

Sincerely,

Michelle Singer

Michelle Singer, Adjudicative Clerk
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

cc: Shantanu Reddy Neravetla, MD, Respondent
Dani Newman, Case Manager
Mike Kramer, Compliance Officer
James McLaughlin, Staff Attorney

Enclosure

H:\ORDER - Combo.doc

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	)	
	)	Master Case No. M2012-1261
SHANTANU REDDY NERAVETLA,	)	
Credential No. MDRE.ML.60229618	)	DECLARATION OF SERVICE
Respondent.	)	BY MAIL
	)	
	)	

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

On May 27, 2014, I served a true and correct copy of the Findings of Fact, Conclusions of Law, and Final Order, signed by the Panel Chair on May 20, 2014, by placing same in the U.S. mail by 5:00 p.m., postage prepaid, on the following parties to this case:

Lish Whitson
Attorney at Law
2121 5th Ave
Seattle, WA 98121

Adam Webber
Falke & Dunphy LLC
30 Wyoming Street
Dayton, OH 45409

Kenneth Lazarus
Lazarus & Associates
1025 Thomas Jefferson St NW
Suite 110-G
Washington DC 20007

Shantanu Neravetla, MD
c/o Lish Whitson
2121 5th Ave
Seattle, WA 98121

Tracy Bahm, AAG
Colin Caywood, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100

DATED: This 27th day of May, 2014.

Michelle Singer, Adjudicative Clerk Office
Adjudicative Clerk

cc: Dani Newman, Case Manager
Mike Kramer, Compliance Officer
James McLaughlin, Staff Attorney

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of: SHANTANU REDDY NERAVETLA, License No. MDRE.ML.60229618, Respondent.	Master Case No. M2012-1261 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Shantanu Reddy Neravetla, the Respondent, by
Lish Whitson, PLLC, per
Lish Whitson, Attorney at Law, and
Falke & Dunphy, LLC, per
Adam Webber, Attorney at Law, and
Lazarus & Associates, per
Ken Lazarus, Attorney at Law

Department of Health Medical Program (Department), by
Office of the Attorney General, per
Tracy Bahm and Colin Caywood, Assistant Attorneys General

PANEL: Warren B. Howe, M.D., Chairperson
Michael T. Concannon, J.D., Public Member
Theresa J. Elders, Public Member
Thomas M. Green, M.D.

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

A hearing was held in this matter on April 21-23, 2014, regarding allegations of a violation of RCW 18.130.170(1). Conditions imposed.

ISSUES

A. Is the Respondent unable to practice with reasonable skill and safety due to any mental or physical condition pursuant to RCW 18.130.170(1)?

B. If so, what is the appropriate sanction under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the following witnesses:

1. Keith Dipdoye, M.D., Residency Program Director, Virginia Mason.
2. Dan O'Connell, Ph.D.
3. Dr. Charles Meredith, Washington Physicians Health Program (WPHP).
4. Brian Owens, Medical Director, Graduate Medical Education (GME).
5. Ed Anderson, Ph.D., Clinical Psychologist, Pine Grove Behavioral Health.
6. Teresa Mulvihill, M.D., Psychiatrist, Pine Grove Behavioral Health.
7. Jason Green, WPHP.

The Respondent presented the following witnesses:

1. Dr. Surender Neravetla.
2. Dr. Soumaya Neravetla.
3. The Respondent.
4. Dr. Massimo De Marchis, Forensic Psychologist, expert witness.
5. Dr. Andre E. Skodol, Professor of Psychiatry, expert witness.
6. Dr. Spencer Eth, Professor of Psychiatry, expert witness.

The Presiding Officer admitted the following Department exhibits at the prehearing conference held April 7, 2014:

Exhibit D-1: Washington State Credential for the Respondent.

Exhibit D-2: Virginia Mason Performance Evaluation Meeting Memorandum, 1st Rotation.

Exhibit D-3: Virginia Mason Performance Evaluation Meeting Memorandum, Mid Rotation.

Exhibit D-4: Virginia Mason Disciplinary Meeting Memorandum, dated August 12, 2011.

Exhibit D-5: Virginia Mason Written Warning for Professionalism/Performance, dated November 29, 2011.

Exhibit D-6: Virginia Mason Mandatory Referral to WPHP with Mandatory Referral Acknowledgement, dated February 9, 2012.

Exhibit D-7: Complaint Letter from WPHP to Medical Quality Assurance Commission (MQAC), dated March 26, 2012.

Exhibit D-8: Pine Grove Evaluation Report, dated June 1, 2012.

Exhibit D-9: MQAC Disruptive Physician Policy Statement, MD2012-01.

The Respondent did not submit any exhibits.[1]

I. FINDINGS OF FACT

1.1 The Respondent was granted a limited license to practice as a resident physician and surgeon in the state of Washington on June 24, 2011. The Respondent's limited license expired on July 31, 2012.

1.2 The Respondent participated in the Virginia Mason Medical Center (VMMC) Transitional Year Residency Program from June 2011 until February 2012. However, his relationship with the Residency Program Director, Dr. Dipdoye, was a conflictful one. On November 29, 2011, Dr. Dipdoye and Dr. Owens, the Graduate Medical Education director, placed the Respondent on probation, and directed him to

[1] The Respondent had three experts testify on his behalf. After their testimony, the Respondent's attorneys attempted to introduce a number of psychological evaluations of the Respondent, done by the three testifying experts (and apparently some additional evaluations conducted by unknown non-testifying persons). These exhibits were denied by the Presiding Officer because, pursuant to WAC 246-11-390(7), they were not offered at the prehearing conference despite the Respondent being given ample opportunity to do so. The Respondent was given full latitude to conduct direct examination of their experts about their evaluations of the Respondent and their findings.

work with Daniel O'Connell, Ph.D. (clinical psychology), an outside consultant to VMMC. Dr. O'Connell's role was that of a communication skills coach to the Respondent. Dr. O'Connell experienced the Respondent as bitterly angry, with little insight and little ability to reflect on his own behavior in relationships with others.

1.3 There was conflicting testimony, much of it hearsay, concerning the Respondent's conduct, performance, attendance, and professionalism while in the residency program at VMMC. With the exception of Dr. O'Connell's testimony, which the Commission finds credible, and the Respondent's own admission of missing certain classes, the Commission makes no finding regarding the Respondent's conduct during his residency except to note that the Respondent had difficulty in relationships with some of his supervisors. However, any residency program has the right to mandatorily refer an intern to the Washington Physicians Health Program (WPHP) for a mental status evaluation, and on February 9, 2013, VMMC did just that.

1.4 On February 16, 2012, the Respondent was initially evaluated by clinical staff at WPHP. Both interviewers (Dr. Meredith and Jason Green) experienced the Respondent as responding to questions in a way that was "disconnected" or as non-responsive to the questions. As the interview progressed, the Respondent became confused, defensive, angry, and upset, raising his voice with the interviewers. In a separate incident later, the Respondent became upset with the receptionist, bringing her to tears. When the interviewers told the Respondent that they were referring him for another evaluation, the Respondent stormed out of the office.

1.5 On May 22, 2013, without informing WPHP, the Respondent presented himself for evaluation at Pine Grove Behavioral Health, one of the three facilities recommended by WPHP. The Respondent underwent separate evaluations by psychiatrist Teresa Mulvihill, M.D., and by clinical psychologist Ed Anderson, Ph.D., and also underwent psychological testing and an addiction medicine evaluation (which revealed no evidence of a substance use disorder). Similar to Dr. O'Connell, Dr. Anderson experienced the Respondent in the interview as defensive, lacking insight, blame-shifting, and denying and minimizing how his internship was at risk at VMMC. Later, VMMC provided multiple collateral documents which Dr. Anderson relied on in forming his final evaluation. The Respondent also provided collateral contacts, who did provide generally positive information.

1.6 The Pine Grove evaluators used the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-4) for their diagnoses. (The DSM-5 was subsequently released, which no longer uses the Axis system of nomenclature.) In her evaluation (done without reference to any collateral materials), Dr. Mulvihill came to the following diagnostic impressions: Occupational problem (Axis I); obsessive-compulsive traits (Axis II); and moderate to severe psychosocial stressors (Axis IV). The final Pine Grove diagnosis, based on psychologist Dr. Anderson's evaluation (which incorporated the VMMC collateral material) came to the following diagnostic impression: Occupational problem (disruptive behavior) (Axis I); and prominent obsessive-compulsive and narcissistic traits (R/O personality disorder NOS with obsessive-compulsive and narcissistic traits) (Axis II).

1.7 In their recommendations, Pine Grove staff indicated that with reasonable psychological and medical certainty they were not comfortable recommending that the Respondent resume responsibilities as a resident physician at that time. Pine Grove further recommended that prior to any attempt to resume duties as a resident physician, the Respondent participate in intensive residential-level treatment of a least six weeks, and that the Respondent agree to a monitoring contract with WPHP. Dr. Meredith of WPHP testified that, while he did not disagree with the recommendation for in-patient treatment, he was surprised by it. The Respondent's experts testified that in-patient treatment was not appropriate for someone who was not diagnosed with a psychological disorder. (*See* footnote 5.) The Commission makes no finding as to the appropriateness of the particular treatment recommendation.

1.8 Because the Respondent had initially indicated to WPHP that he would not participate in another evaluation, and because WPHP had had no contact with the Respondent and did not know where he was (and did not know he had gone to Pine Grove),[2] WPHP notified the Medical Quality Assurance Commission (MQAC[3]) and indicated their concern that the Respondent's ability to practice medicine with reasonable safety was potentially impaired. When the Pine

[2] In fact, the Commission notes that throughout this process, the Respondent attempted to control the flow of information about him by being non-cooperative, non-communicating, evasive in his responses to questions, and by such actions as refusing to sign consent forms to allow evaluators to contact collateral sources.

[3] The abbreviation "MQAC" is used herein to indicate the overall Medical Commission, including the panel of the Commission that makes the decision to file Statement of Charges against respondents. The term "Commission" as used herein refers to the panel that actually heard this case – a separate and distinct panel who, although members of MQAC, were not involved in any charging or investigation of this case.

Grove evaluation was issued, the Respondent refused the recommended treatment, and was subsequently terminated from the residency program at VMMC. Subsequent to that, MQAC filed the current allegations.

1.9 Credibility Findings: (a) The Commission finds the testimony of Charles Meredith, M.D., and Jason Green of WPHP to be credible. Their descriptions of how the Respondent reacted to being interviewed were believable and consistent with each other. The Commission finds Ed Anderson, Ph.D., of Pine Grove credible as to his observations of the Respondent (which occurred before he received the reports from VMMC) and as to his explanation of the difference in the DSM-IV between a "disorder" and a "condition." The Commission finds the testimony of Daniel O'Connell, Ph.D. to be credible and unbiased. The Commission finds the testimony of Teresa Mulvihill, M.D., to be credible.[4]

[4] Dr. Mulvihill did a two-hour psychiatric interview of the Respondent and diagnosed him as having an occupational problem with obsessive compulsive traits. The fact that Dr. Mulvihill's evaluation and Dr. Anderson's final evaluation arrived at a somewhat different conclusions is of no import. The Commission recognizes that the field of psychology, as well as the DSM, are ever evolving. Dr. Anderson testified that he places great stock on collaborative reports, whereas Dr. Mulvihill did not have either the collaborative reports or the psychological testing results for her evaluation. The common denominator in both analyses, however, was that the Respondent fit the classification of "occupational problem." An occupational problem is not a psychiatric or personality "disorder." It is, however, recognized by the DSM as a "condition." (Even the Respondent's expert, Dr. Eth, agreed that the diagnosis of occupational condition was accurate for the Respondent.) While the Commission does agree, and finds that the Respondent has an occupational problem, it should be pointed out that too much of the hearing was spent on argument as to weaknesses of the DSM, the difference in the DSM-4 manual used by Pine Grove versus the current DSM-5 manual, or whether the Respondent could even be categorized at all under the DSM – discussions and argument that miss the point. A respondent does not have to have fit into any particular type of diagnostic label peghole to trigger RCW 18.130.170(1). Within the parameters of RCW 18.130.170(1), the use of psychological/psychiatric labels is only a useful language system to describe the impact that conduct, mental processes, and the ability to form relationships have on professional skill and safety. In this case, as indicated, the Commission finds that the Respondent did have an "occupational problem" (a condition) that disrupted his internship. The observable behaviors that contributed to that occupational problem (anger, blaming, disconnect, and inability to track questions) were still evident in the Respondent at the hearing. For reasons explained in this Order, those behaviors do impact the ability to practice with reasonable skill and safety.

(b) The Commission finds the testimony of the Respondent to be credible, in the sense that it was an honest representation of the difficulty he had in tracking the Commission's questions; the difficulty, if not the impossibility, he had of reconciling the descriptions of others about him versus his own experience of events when he is under stress; and the dramatic difference in his ability to articulate in great detail events or areas that interest him and the bleakness of his recollection of areas or events that he felt defensive about. To the extent that these themes contributed to the diagnosis of occupational problem, they are still evident.

(c) The Commission does not make a credibility finding on the testimony of Dr. Dipboye and Dr. Owens, in so far as they were each relying on information told to them by others. The Commission finds the testimony of the Respondent's father and sister, Dr. Surender Neravetla and Dr. Soumya Neravetla, to be sincere, but colored by their love for and protection of the Respondent. The Commission finds the testimony of the Respondent's experts, Dr. Marchis, Dr. Skodol, and Dr. Eth, credible, but the weight of their testimony is minimal since their evaluations were aimed at ruling out a psychiatric or personality "disorder."[5]

1.10 Discussion: (a) The issue in this case is a subtle one. The Respondent's attorneys argue that Dr. Dipboye was prejudiced against the Respondent, having formed an opinion of him based solely on hearsay, and that because of this and

[5] There was no evidence presented, nor does the Commission find, that the Respondent suffers from a personality disorder (an enduring pattern of marked dysfunction that is pervasive, inflexible, and appears stable over time). Some of the evaluators talked about traits or conditions, impressions or labels (all of which may be transient, intermittent, or acute, but not chronic or triggered by outside events), but nothing that rose to the level of a diagnosable personality disorder. But again (*See* footnote 4), a condition does not have to be a diagnosable disorder to qualify as a triggering event for a RCW 18.130.170(1) action.

perhaps a need to protect VMMC, he mounted a campaign to get rid of the Respondent, including tainting the opinions of the professionals at WPHP and Pine Grove. However, for the reason previously indicated (any internship program has the right to refer an intern to WPHP for an evaluation), the Commission makes no finding on the Respondent's conduct at VMMC except to accept Dr. O'Connell's testimony as credible and to note that the Respondent had difficulty in relationships with some of his supervisors. Clearly the Respondent is very intelligent and passionate about his chosen interest of ophthalmology, but that is not the issue before the Commission. The issue before the Commission is the capacity of the Respondent to practice with reasonable skill and safety. The Commission does not rely on how the Respondent came to WPHP for evaluation. But this is where the issue becomes subtle: the Department alleges that the Respondent suffers from the condition of Disruptive Physician Behavior. Dr. Anderson from Pine Grove testified that a diagnosis of Disruptive Physician Behavior is almost 100% dependent upon "collateral information" (reports from the workplace), that is, that a person could undergo a battery of psychological tests that all fell within the normal range, but still receive a diagnosis of Disruptive Physician Behavior based on the collateral information. Thus, the Respondent's attorneys argue, Dr. Dipboye was in a unique position to shape the Respondent's diagnosis by providing one-sided and prejudicial collateral information. The Commission rejects this argument. The testimony of the four witnesses who were in the best position to see the Respondent under stress (Charles Meredith, M.D.; Jason Green of WPHP; Ed Anderson, Ph.D., of Pine Grove; and Daniel O'Connell, Ph.D.) was consistent that

the Respondent was upset, argumentative, angry, blaming others for his situation, and disconnected from the seriousness of the reports about him. More importantly, this was exactly the same demeanor the Respondent displayed while testifying at the hearing.

(b) The Commission concurs with the experts who found that the Respondent was suffering from an occupational problem, and that this occupational problem was disruptive to his internship; that it did interfere with his ability to communicate and work with others; and, that if it persists, it would impede his ability to practice with reasonable skill and safety. Today's physicians work in a team environment, and the ability to communicate and cooperate with other members of the health care team is crucial to the delivery of good health care. When conduct such as inability to work with others, uncooperative attitudes, poor responses to corrective action, confusing communication, etc., rise to the level where multiple independent professionals conclude there is an occupational problem, then patient care is affected. Exhibit D-9, the MQAC policy statement regarding disruptive behavior, defines disruptive behavior as including conduct that interferes with one's ability to work with other members of the health care team.[6]

[6] As stated in that Policy: "The importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasingly evident. Such behavior disrupts the effectiveness of team communications and has been shown to be a root cause in a high percentage of anesthesia-related *sentinel events*. *The consequences of disruptive behavior* include job dissatisfaction for staff, including other physicians and nurses; voluntary turnover; increased stress; patient complaints; malpractice suits; medical errors; and compromised patient safety." (Footnotes omitted.)

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), cert. denied, 535 U.S. 904 (2002).

2.3 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.4 The Department proved by clear and convincing evidence that the Respondent's ability to practice with reasonable skill and safety was sufficient impaired by an occupational problem to trigger the application of RCW 18.130.170(1), which states:

> Capacity of license holder to practice — Hearing — Mental or physical examination — Implied consent.
>
> (1) If the disciplining authority believes a license holder may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety. If the disciplining authority determines that the license holder is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

2.5 In determining the appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The conduct in this case is not described in a sanctioning schedule in Chapter 246-16. Thus the panel used its judgment to determine sanctions. WAC 246-16-800(2)(d). The panel considers the facts of this case unique and finds no applicable aggravating or mitigating factors from WAC 246-16-890.

2.6 The Department requests that the Respondent be ordered to comply with the Pine Grove treatment recommendations. The Commission declines to do this. The Respondent's license has expired; he resides in another state; and it is unclear whether he would ever seek re-licensure in Washington. Further, substantial time has passed since his Pine Grove evaluation. Protection of the public in the state of Washington only requires the imposition of the following condition: that should the Respondent ever seek licensure in the state of Washington for a health care credential, that he undergo a new psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation.

III. ORDER

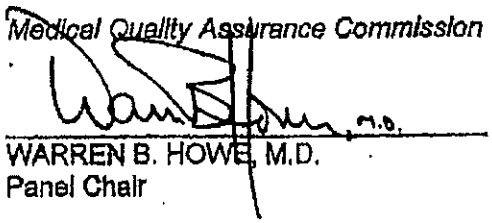
3.1 In the event that the Respondent seeks licensure in the state of Washington for a health care credential, the Respondent shall undergo a psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation.

3.2 The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this order.

3.3 The Respondent may not seek modification of this order.

Dated this 20th day of May, 2014.

Medical Quality Assurance Commission



WARREN B. HOWE, M.D.
Panel Chair

CLERK'S SUMMARY

Charge	Action
RCW 18.130.170(1)	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may **file a petition for reconsideration.** RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx